The Continuing Need for Medicaid Reform

TESTIMONY

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By

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Mr. Chairman and Members of the Subcommittee. Thank you for inviting me to appear before the Subcommittee to testify about the continuing need to reform the Medicaid program, despite the recent slowdown in Medicaid spending. My name is Gail Wilensky. I am currently the John M. Olin Senior Fellow at Project HOPE, an international health education foundation and the chair of the Physician Payment Review Commission. I am here today, however, not to represent either of these organizations but to speak from my experiences as the Administrator of the Health Care Financing Administration during the Bush Administration and from the knowledge of Medicaid that I have gained as a health policy analyst.

Background

Medicaid is the nation's program that is most focused on helping states finance the health care needs of our most vulnerable populations. Currently Medicaid is funding services for about 42 million low income individuals. Medicaid is a state-administered program that is funded jointly by the Federal and state governments. The states receive Federal matching funds to finance Medicaid based on a formula that varies with the state's per capita income. The Federal share ranges from 50 percent to 83 percent of the total funding. The Medicaid program allows states substantial flexibility, in terms of the services that can be provided, the populations that can be covered and the way the program is administered.

Medicaid is frequently maligned for providing expensive, fragmented care to people in high cost and inappropriate settings. By most measurements, however, Medicaid has met its basic objective of providing health care to selected categories of low income individuals. While we should applaud the successes Medicaid has achieved, we should also acknowledge the need to change and reform the program.

The Need for Reform

Despite the slowdown in the growth of Medicaid spending that occurred between 1995 and 1996, the experience of the last 15 years, as well as the recently released CBO projections of Medicaid spending for the decade, indicate a continuing need to be concerned about Medicaid spending. In addition to spending concerns, the issues raised during the last session of Congress about the need to make Medicaid a more flexible program and to lessen the burdens imposed on the states responsible for administering the program, remain relevant.

There are a variety of reasons that explain the rapid growth in spending that Medicaid experienced during the 1980's and up to 1995 which combined together make Medicaid the second largest category of state expenditure after education. These include increasing caseloads, additional requirements that have been placed on the state by the Federal government and the discovery of what were effectively Federal-only dollars during the early 1990's.

One reason for the increased spending on Medicaid during the last decade is the increased use of mandates by the Federal government. These mandates included new populations that had to be covered such as all pregnant women and children up to age 6 with family income up to 133 percent of the poverty line, all children born after 1983 to families in poverty, and increased numbers of elderly through the Qualified Medicare Beneficiary program. Additionally, new services also had to be provided such as all needed services discovered during a screening visit under the EPSDT program, whether or not otherwise covered by the state's Medicaid program. It also included new requirements about how and by whom services were to be provided, particularly for people in nursing homes.

A second reason is that new options were made available regarding the populations that could be covered under Medicaid, particularly women and children. This, along with the

flexibility to bring in previously uncovered populations provided through the 1115 waiver process, allowed states to shift what previously had been state-only dollars to Medicaid, which made them no worse than Federal/state dollars and in some cases, Federal only dollars.

A third factor explaining the rapid growth of Medicaid spending was the development by several states of creative financing strategies to fund their share of the match. This was a critical moment in the program's history, because it undermined the basic premise of the financial structure of Medicaid-- that funding be shared through a Federal match of State monies. Matching grants presume that those responsible for spending decisions have a reasonable stake in the program's costs. In fact, the only real cost containment mechanism that exists in the Medicaid program is the State s share of the costs. By its structure, Medicaid is an open ended matching program, with no limit on Federal payment.

The discovery of strategies by states to enhance their Federal matching share, at little or no cost to themselves, along with the other pressures to increase spending not very surprisingly resulted in producing explosive growth rates during the early 1990's. Medicaid, which had been growing at rates that varied between 8 percent and 12 percent earlier in the 1980's, grew at rates of almost 19 percent, 32 percent and 28 percent for the years 1989-90, 1990-91 and 1991-92, respectively. From 1992 to 1995 Medicaid spending grew at rates of 9.5 percent per year, considerably slower than the early nineties but still more than double the rate of growth of the rest of the Federal budget.

Lessons Learned From Donations and Provider Taxes

States showed remarkable creativity in the strategies they devised to enhance their share of Federal dollars. West Virginia started the process in 1986, but at least 30 states were involved by July of 1991. The specific strategies varied substantially, but basically each worked in the following way. A state borrowed money from providers through donation or tax programs. The money was used as the state's share of Medicaid and was matched at least dollar for dollar by Federal funds. The state would then increase Medicaid payments to reimburse providers for the donations or taxes they had paid. In many states, providers were guaranteed to get back at least as much as they donated or paid in provider-specific taxes through hold-harmless mechanisms. The funds were most frequently distributed via "disproportionate share" payment strategies (payments to hospitals providing a disproportionate share of services to low income populations) that allowed states to reimburse institutions in excess of the amounts spent providing care to low income people.

Legislation was passed in the fall of 1991 that limited the amount of revenue that could be used for purposes of Federal match from taxes that were limited to medical providers, eliminated the use of donation strategies, and limited the amount of funds that could be received as disproportionate share payments. States had a minimum of one year to comply with the new requirements (some states whose legislatures only met on a biannual basis had two years to comply). As frequently happens, some states had been much more aggressive than others in increasing their effective Federal match rate. Those states were allowed to maintain their high rates of provider taxes for a period of time and were allowed to keep very large levels of disproportionate share spending while other states were limited in what they could introduce or claim.

Legislation was also passed in 1993 which limited disproportionate spending allocations

to the amounts institutions had spent furnishing hospital care to Medicaid-eligible and uninsured patients (less the amount they had received directly from Medicaid for providing services to Medicaid eligible individuals). This meant that the total money received from Medicaid couldn't exceed the cost of providing hospital services to low income populations, something which had happened with some frequency before the legislation was passed.

The experience with provider taxes, donations and disproportionate share spending was a rude awakening regarding the fungibility of money. In general, the 1991 legislation, combined with the 1993 legislation, shut down the abusive provider tax and donation funding arrangements which the states had adopted.

The bigger concern for today has to do with intergovernmental transfers. Intergovernmental transfers were an area of concern in 1991, but those of us working on the issue at HCFA were unable to devise a rule which would distinguish between an intergovernmental transfer that represented a legitimate transfer between levels of government and the movement of funds which results in only new Federal money coming into the program. It is particularly problematic when the county or state is paying itself because it owns the hospital and is putting up its share of the match with an intergovernmental transfer. The absence of an ability to distinguish appropriate uses and abusive uses of intergovernmental transfers is a good reminder that money is fungible and that reliance on the use of state matching as a cost containment strategy is a genie that can never be put back into the bottle.

1995-1996: The Temporary Slowdown in Spending

Last year, when Medicaid spending was projected to continue increasing at a rate of nine to ten percent per year, many observers were concerned that reform proposals which slowed spending to five or six percent per year would cause draconian changes in the program. This year, some of those same observers are wondering why there needs to be any reform in Medicaid, given the very low growth rate of 3.3 percent reported for 1995-1996. The short answer is that no one expects this very low rate of spending growth to continue and the need for more state flexibility in program design continues as well. CBO currently projects a spending growth on Medicaid at 7.7 percent per year for the period 1996-2002, down from the previous projection of 9.7 percent per year but still substantially faster than the rest of the budget, exclusive of Medicare and interest on the debt.

There are a number of reasons – some substantive and some artificial—as to why we should not be surprised that Medicaid spending has slowed dramatically. First, enrollment growth has slowed substantially. CBO is now projecting enrollment growth rates of 1.3 percent to 1.6 percent per year whereas last year they were projecting rates to 2.7 percent per year. This compares to enrollment growth rates of 7.9 percent in the period 1988 - 1992. Second, there has been a rapid growth in the use of managed care, primarily for the acute care population. As of 1995, 42 states and the District of Columbia has received 1915b waivers to allow the use of mandatory managed care and as of 1996, 13 million recipients were enrolled in managed care programs.

But there are clear reasons why the 1995 - 1996 growth rate should be regarded as artificially low. One reason is that states were attempting to built up the 1995 base in anticipation of the passage of legislation enacting a block grant which would use 1995 as the base year. A second reason is that some of the state have been shifting what had

previously been Medicaid spending on chronic care to the Medicare program, in part explaining the very rapid rise in the use of home care and skilled nursing care under Medicare. If Medicare adopts a prospective payment system for either or both home care and skilled nursing care, as is proposed in the President's Budget, it will no longer be as fiscally attractive to continue shifting the funding source for these two services. A third reason is that some of the early easy savings from requiring acute care populations to enroll in managed care have already been captured.

CBO projects that Medicaid spending will grow at rates greater than eight percent per year after 2002. If the fiscal pressures on states were to increase, either from an economic slowdown or as a result of the recently enacted welfare changes, I believe the growth in spending would be even greater then the rates projected by CBO. Given the difficulties experienced in writing Medicaid regulations which effectively limit intergovernmental transfers to appropriate uses for purposes of Medicaid matching, the Federal government remains vulnerable to the rapid rates of increase that can occur when the only increased funds in Medicaid come from the Federal government.

The Choices for a Reformed Program

The same two fundamental choices for limiting Federal government liability under Medicaid discussed in the 104th Congress remain the choices today. One choice is to use a capped payment per person covered under current (or changed) Medicaid eligibility rules as was proposed during the last Congress by the President and as was included in his recently submitted Budget. The other option is to use a block grant, where the payment is based on a formula, such as projected enrollment or population at risk times a growth factor in spending, as was proposed and passed by the 104th Congress but vetoed by the President.

Per capita caps retain the concept of an entitlement between the Federal government and the individual but limits the amount the Federal government will match to a preset level. It therefore limits the Federal government's fiscal liability at a per person level but protects the states from being fully at risk for increases in the Medicaid eligible population. Per capita caps don't provide the fiscal protection to the Federal government that comes with a block grant but it imposes a spending discipline not currently present and very likely to be needed in the future.

The philosophical issue of whether to continue the individual entitlements from the Federal government to the individual or to leave the determination and distribution of services and benefits to the states does not appear to be a salient issue in the 105th Congress. However, the need for Medicaid spending constraints and the need for increased state flexibility is as salient as ever. Thus, the continuing need for Medicaid reform remains an issue for the 105th Congress.